CERTIFIED RETURN RECEIPT REQUESTED NO. P049595070

Rec'd 5-28-91

STATE OF CONNECTICUT

BOARD OF EXAMINERS FOR NURSING

Department of Health Services v.

Renee D. Mix, R.N., License No. R41448

75 Avon Place, Apt. 403

Springfield, MA 01105

CASE PETITION NO. 900306-10-015

MEMORANDUM OF DECISION

INTRODUCTION

The Board of Examiners for Nursing (hereinafter the "Board") was presented by the Department of Health Services (hereinafter the "Department") with a Statement of Charges dated October 26, 1990.

The Statement of Charges alleged violations of certain provisions of Chapter 378 of the General Statutes of Connecticut. The Board issued a Notice of Hearing dated October 30, 1990. The hearing took place on November 29, 1990, January 8, 1991 and February 27, 1991 in Room 112, National Guard Armory, Maxim Road, Hartford, Connecticut.

Each member of the Board involved in this decision attests that he/she was present at the hearing or has reviewed the record, and that this decision is based entirely on the record and their specialized professional knowledge in evaluating the evidence.

FACTS

Based on the testimony given and the exhibits offered into evidence, the Board made the following findings of fact:

1. Renee D. Mix, hereinafter referred to as Respondent, was issued Connecticut Registered Nurse license number R41448 on June 1, 1987. The Respondent is, and was at all times referenced in the Statement of Charges, the holder of said license. (State Exhibit 1, p. 7; Respondent Exhibit A)

2. Pursuant to the General Statutes of Connecticut, Section 4-182(c), the Respondent was provided full opportunity prior to the institution of agency action to show compliance with all the terms for the retention of her license. (Department Exhibit 1, p.p. 1-2)

3. The Respondent was aware of the time and location of the hearing. Department Exhibit 1 indicates that notice of the location and time of this hearing were delivered by certified mail to the Respondent.

4. The Respondent was present on all dates of the hearing and was represented by counsel.

5. The Respondent was employed and working in the capacity of a registered nurse at the hospital of the Connecticut Correctional Institution, Somers, Connecticut on January 5, 1990. (Respondent Exhibit A)

6. On January 5, 1990 the Respondent provided nursing care to inmate Leonard Augeri, hereinafter referred to as the "patient". (Respondent Exhibit A; Hearing Transcript, February 27, 1991, p.p. 32-44)

7. On January 5, 1990 at approximately 6:00 p.m. the Respondent failed to properly administer medication to the patient in that, while it was ordered that the patient received 7.5 milligrams of Morphine Sulfate IM (intramuscular) (State Exhibit 2, p.9), the Respondent administered approximately 112.5 milligrams (7.5 cubic centimeters) of Morphine Sulfate IM. (Hearing Transcript, January 8, 1991, p. 3; Hearing Transcript, February 27, 1991, p.p. 36-37)

8. The patient died on January 5, 1990. The Respondent discovered that the patient appeared to be dead at approximately 10:30 p.m. (Hearing Transcript, February 27, 1991, p.p. 40-41) The patient was pronounced dead at 11:14 p.m. (State Exhibit 2 and 2B) The Office of the Chief Medical Examiner determined that the final cause of death was "morphine toxicity." (State Exhibit 6, p. 5)

9. After administering the Morphine Sulfate IM to the patient, the Respondent failed to monitor the patient's vital signs or otherwise properly assess the patient's condition, (State Exhibit 2) even though the patient's physician had told Respondent "...to watch for signs and symptoms of respiratory distress...." (Hearing Transcript, February 27, 1991, p. 40) Between approximately 6:00 p.m. and 10:30 p.m. on January 5,

1990, the Respondent failed to recognize the significance of the patient's deteriorating condition following the administration of Morphine Sulfate IM. (Record)

10. The Respondent failed to properly document the administration of Morphine Sulfate to the patient, in that the Respondent documented that the patient was medicated with "7.5 mg." of Morphine Sulfate when in fact 7.5 cc's were administered. (State Exhibit 2, p. 12; State Exhibit 10: Record)

11. The Respondent failed to properly document the events of the medical emergency regarding the patient on January 5, 1990 in that the Respondent failed to document in the patient's medical record that she found the patient unresponsive and she failed to document the subsequent telephone conversations that she had with Timothy Silvis, M.D., regarding Dr. Silvis' order that the patient be given Narcan. (Hearing Transcript, January 8, 1991, p.p. 19-21; p.p. 46-47; Hearing Transcript, February 27, 1991, p.p. 41-43; State Exhibit 2)

DISCUSSION AND CONCLUSIONS

The FIRST COUNT SUBSECTION 5a. alleges the Respondent, while employed as a registered nurse at the hospital of the Connecticut Correctional Institution, Somers, Connecticut on January 5, 1990, "failed to appropriately and/or properly administer medication in that, while it was ordered that the patient receive 7.5 milligrams of Morphine Sulfate IM, she administered approximately 112.5 milligrams (7.5 cubic centimeters) of Morphine Sulfate IM".

The Respondent admits this charge. Specifically, in a statement read by her attorney the Respondent admits "That in regard to the incident which occurred on January 5th, 1990...she mistakenly and regretfully administered 7.5 cc's instead of 7.5 mg's of Morphine Sulfate IM..." (Hearing Transcript January 8, 1991 p.3)

The above referenced conduct is prohibited by the General Statutes of Connecticut Section 20-99(b), as "...(2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...."

Based upon Respondent's admission and finding of Fact No. 7, the Board concludes that the Respondent violated the General Statutes of Connecticut Section 20-99(b)(2) by conduct specified in the First Count, Subsection 5a.

The FIRST COUNT SUBSECTION 5b. alleges the Respondent, while employed as a registered nurse at the hospital of the Connecticut Correctional Institution, Somers, Connecticut on January 5, 1990, "failed to appropriately and/or properly administer medication in that, while Narcan was ordered, no Narcan was administered to the patient." The Respondent denies this charge. (Respondent's Exhibit A).

The alleged conduct is a violation of the General Statutes of Connecticut Section 20-99(b), which prohibits "...(2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...."

The Board concludes that insufficient evidence exists to substantiate this charge. Therefore, the First Count Subsection 5b is dismissed.

The FIRST COUNT SUBSECTION 5c. alleges the Respondent, while employed as a registered nurse at the hospital of the Connecticut Correctional Institution, Somers, Connecticut on January 5, 1990, "failed to adequately and/or properly assess, monitor, and recognize the significance of the decedent's (patient's) deteriorating condition following the administration of medication." The Respondent denies this charge. (Respondent's Exhibit A)

The medical record of the patient (Department Exhibit 2 p.p. 9-12 and Department Exhibit 2B) lacks documentation that the Respondent obtained vital signs or otherwise monitored the patient's condition following the Respondent's administration of Morphine Sulfate IM to the patient. (Fact No. 9)

Credible testimony was received from the Respondent, wherein she stated, "I was constantly going pass (sic) the door, not going in but peeking to see how he was doing...." (Hearing Transcript February 27, 1991 p.40) (Fact No. 9) The Board finds as a matter of law that merely "peeking" is not an accepted nursing practice in monitoring or assessing a patient's condition.

The above referenced conduct is a violation of the General Statutes of Connecticut Section 20-99(b) which prohibits "...(2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...."

Based upon the Board's finding of Fact No. 9, the Board concludes that the Respondent violated the General Statutes of Connecticut Section 20-99(b)(2) by conduct specified in the First Count Subsection 5c.

The FIRST COUNT SUBSECTION 5d. alleges the Respondent, while employed as a registered nurse at the hospital of the Connecticut Correctional Institution, Somers, Connecticut on January 5, 1990, "failed to adequately, completely and/or properly document the administration of medication." The Respondent denies this charge. (Respondent's Exhibit A)

The above referenced conduct is a violation of the General Statutes of Connecticut Section 20-99(b), which prohibits "...(2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...."

Based upon the Board's finding of Fact No. 10, the Board concludes that the Respondent has violated the Connecticut General Statutes Section 20-99(b)(2) by conduct specified in the First Count Subsection 5d.

The FIRST COUNT SUBSECTION 5e. alleges the Respondent, while employed as a registered nurse at the hospital of the Connecticut Correctional Institution, Somers, Connecticut on January 5, 1990, "failed to adequately, completely and/or properly document the patient's vital signs or condition." The Respondent denies this charge. (Respondent's Exhibit A)

The above referenced conduct is a violation of the General Statutes of Connecticut Section 20-99(b), which prohibits "...(2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...."

A review of the medical record of the patient (State Exhibit 2) indicates that the Respondent did not document the patient's vital signs or write any assessment of the patient's condition, after the administration of Morphine Sulfate to the patient.

This Board previously found that the Respondent failed to properly assess and monitor the patient after giving him an injection of Morphine Sulfate. (Fact No. 9) Therefore, the lack of documentation accurately reflects the Respondent's failure to assess and monitor the patient. Having previously concluded that the Respondent violated Section 20-99(b)(2) for the failure to monitor and assess the patient, this Board cannot conclude that the Respondent merely failed to document the patient's vital signs or condition, as alleged.

Therefore, the First Count Subsection 5e is dismissed.

The FIRST COUNT SUBSECTION 5f. alleges that the Respondent, while working as a registered nurse at the hospital of the Connecticut Correctional Institute, Somers, Connecticut on January 5, 1990, "failed to timely, accurately and/or properly call a code or medical emergency." The Respondent denies this charge. (Respondent's Exhibit A).

The described conduct is a violation of the General Statutes of Connecticut Section 20-99(b), which prohibits "...(2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...."

The Board concludes that insufficient evidence exists to substantiate this charge. Therefore, the First Count Subsection 5f is dismissed.

The FIRST COUNT SUBSECTION 5g. alleges that the Respondent, while employed as a registered nurse at the hospital of the Connecticut Correctional Institution, Somers, Connecticut on January 5, 1990, "failed to timely, accurately and/or properly perform or direct performance of CPR." This charge was withdrawn by the Department. (Hearing Transcript January 8, 1991 p.2)

The FIRST COUNT SUBSECTION 5h. alleges that the Respondent, while employed as a registered nurse at the hospital of the Connecticut Correctional Institution, Somers, Connecticut on January 5, 1990, "failed to adequately, properly and/or completely document the events of the medical emergency." The Respondent denies this charge. (Respondent's Exhibit A)

The above referenced conduct is a violation of the General Statutes of Connecticut Section 20-99(b), which prohibits "...(2) illegal conduct, incompetence or negligence in carrying out usual nursing functions...."

Based upon the Board's findings of Fact No. 11, the Board concludes the Respondent violated the General Statutes of Connecticut Section 20-99(b)(2) by conduct specified in the First Count Subsection 5h.

ORDER

Pursuant to its authority under the General Statutes of Connecticut Sections 19a-17 and 20-99 the Board hereby orders the following:

1. The license of the Respondent, for Subsection 5a of the FIRST COUNT, be suspended for a minimum of one (1) year followed by two (2) years of probation after completion of the suspension.

2. The license of the Respondent, for Subsections 5c, 5d and 5h of the FIRST COUNT, be suspended for a minimum of one (1) year followed by two (2) years of probation after completion of the suspension, as follows:

   A. as to the First Count, Subsection 5c. one (1) year suspension and two (2) years probation;

   B. as to the First Count, Subsection 5d. one (1) year suspension and two (2) years probation;

   C. as to the First Count, Subsection 5h. one (1) year suspension and two (2) years probation;

   D. the one (1) year suspension referenced in A, B and C above, are to run concurrent with the suspension referenced in No. 1 of the Order for an effective suspension of one (1) year;

E. the two (2) year probationary periods referenced in A, B and C above, are to run concurrent with the probation referenced in No. 1 of the Order for an effective probationary period of two (2) years;

F. the two (2) year probationary period shall follow the one (1) year suspension.

3. If any of the following conditions of probation are not met, the Respondent's license may be immediately revoked.

A. She shall provide a copy of this Memorandum of Decision to her employer. The Board shall be notified in writing by her employer as to receipt of a copy of this Memorandum of Decision.

B. She shall not accept employment as a nurse for a personnel provider service or home health care agency for the period of her probation.

C. She shall be responsible for the provision of monthly employer reports from her nursing supervisor (i.e. Director of Nursing) due on the first business day of every month during the first year of probation.

D. She shall be responsible for the provision of bi-monthly employer reports from her nursing supervisor during the second year of her probation. Bi-monthly reports are due by the first business day of January, March, May, July, September and November.

E. Said reports cited in (C) and (D) above, shall include documentation of her ability to safely and competently practice nursing and an evaluation of her ability to administer medications. Said reports shall be issued to the Board at the address listing in paragraph (K) below.

F. During the first year of probation she must successfully complete a Board approved pharmacology course which shall include a minimum of thirty (30) hours of theory and forty-five (45) hours of clinical application.

G. The course cited in (F) above must be approved by the Board prior to commencement.

H. She shall be responsible for the provision of a report from the director, of the course cited in (F) above, certifying her successful completion. This report shall be issued to the Board at the address listed in (K) below and is due by August 31, 1993.

I. The Connecticut Board of Examiners for Nursing must be informed, in writing, prior to any change of employment.

J. The Connecticut Board of Examiners for Nursing must be informed, in writing, prior to any change of address.

K. All correspondence and reports are to be addressed to:

4. Any deviation from the terms of probation without prior written approval by the Board of Examiners for Nursing will constitute a violation of probation and will subject the Respondent to sanctions under the General Statutes of Connecticut Section 19a-17(a) and (c) including but not limited to the revocation of her license. Any extension of time or grace period for reporting granted by the Connecticut Board of Examiners for Nursing shall not be a waiver or preclude the Board's right to take action at a later time. The Connecticut Board of Examiners for Nursing shall not be required to grant future extensions of time or grace periods. Notice of revocation or other disciplinary action shall be sent to her address of record (most current address reported to the Licensure and Renewal Section of the Division of Medical Quality Assurance of the Department of Health Services or the Connecticut Board of Examiners for Nursing).

5. The date of suspension shall commence on August 1, 1991.

The Respondent, Renee D. Mix, is hereby directed to surrender her Registered Nurse License No. R41448 and current registration to the Board of Examiners for Nursing, 150 Washington Street, Hartford, Connecticut 06106, on or before August 1, 1991.

The Board of Examiners for Nursing hereby informs the Respondent and the Department of Health Services of the State of Connecticut of this decision.

Dated at Hartford, Connecticut, this 22nd day of May, 1991.

BOARD OF EXAMINERS FOR NURSING

By Sister Jane M. Murphy

6238Q

CERTIFIED MAIL - RETURN RECEIPT REQUESTED NO. P410482206

Ex. 1

6-21-91

STATE OF CONNECTICUT

BOARD OF EXAMINERS FOR NURSING

Department of Health Services v.

Renee D. Mix, RN, License No. R41448

23 Irvington Street

Springfield, MA 01108

AMENDED MEMORANDUM OF DECISION

On May 22, 1991 the Board of Examiners for Nursing (hereinafter the "Board") issued a Memorandum of Decision ordering registered nurse license No. R41448 of Renee D. Mix (hereinafter the "Respondent") to be suspended for one (1) year followed by two (2) years of probation after completion of the suspension. Said suspension was ordered to commence on August 1, 1991.

On June 19, 1991 the Board was presented with the Respondent's Motion To Commence Suspension, dated June 17, 1991, requesting that said ordered suspension commence on July 1, 1991. The Respondent states in her motion she will not appeal the suspension.

ORDER

Pursuant to its authority under the General Statutes of Connecticut Sections 19a-17 and 20-99 the Board grants the Respondent's Motion To Commence Suspension and hereby orders the following:

The date of suspension of the license of the Respondent shall commence on July 1, 1991. Other than this change in the starting date of the suspension, the May 22, 1991 Memorandum of Decision remains in full force and effect.

The Respondent, Renee D. Mix, is hereby directed to surrender her Registered Nurse License No. R41448 and current registration to the Board of Examiners for Nursing, 150 Washington Street, Hartford, Connecticut 06106, on or before July 1, 1991.

The Board of Examiners for Nursing hereby informs the Respondent and the Department of Health Services of the State of Connecticut of this decision.

Dated at Hartford, Connecticut, this 19th day of June, 1991.

BOARD OF EXAMINERS FOR NURSING

By Estelle Jarel M. Murphy R.N.